Child Welfare Privatization
Summary of National Trends: A Synthesis of Research

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PREFACE

There have been four major projects in recent years that have focused on management and finance and privatization changes occurring in state child welfare agencies across the nation—the Child Welfare League of America (CWLA) Finance & Contracting 50-State Surveys, the Health Care Reform Tracking Project, George Washington University's study of contracting practices, and the Children's Rights study.

Beginning in 1996, the *Child Welfare League of America (CWLA)* began to systematically identify, track, and describe child welfare *managed care* and privatized initiatives that changed management, finance, ad contracting in an attempt to stimulate better results for children and their families. Findings from 50-State surveys have been periodically published and disseminated.

Since 1995, the *Health Care Reform Tracking Project*[1] has been tracking publicly financed managed care initiatives – principally, Medicaid managed care reforms -- and their impact on children with mental health and substance abuse disorders and their families. A subset of those studies involve changes in the child welfare system.

In 2002*, George Washington University (GWU)* completed an analysis of contracts and site visits in four states to examine how contracting for child welfare and behavioral health care services facilitated cross-system collaboration and service coordination. The goal was to highlight the real world experiences and "lessons learned" that others may draw upon when designing similar contracts care.

Finally, with funding from the Annie E. Casey Foundation, *Children's Rights* conducted an in-depth study of six privatized child welfare initiatives to examine the extent to which benefits are achieved by such projects and to determine what, if any, negative consequences occurred for children and families as a result of the privatized models. The report identifies themes that were common to many, if not all, of the initiatives and it provides specific recommendations for consideration by states or communities intending to use privatization.[2]

This summary of national research distills findings from each of these and other privatization reports. The trends section is adapted primarily from a CWLA Issue Papers funded by the Center for Health Care Strategies [3] and from the Children's Rights report.

I. NATIONAL TRENDS: A SYNTHESIS OF PRIVATIZATION RESEARCH

This section places privatization in an historical context, defines elements that differentiate current efforts from traditional arrangements; and, provides a synthesis of research findings on the prevalence and types of privatization initiatives, including a discussion of key design features and changes that have occurred over time. Examples are inserted to illustrate different aspects of various privatized models. The section concludes with commentary on challenges, opportunities and recent developments.

The Evolution of Privatization

Although there is no single definition of *privatization,* the term generally has come to refer to a range of strategies that involve "the provision of publicly funded services and activities by non-governmental entities".[4]

Even before the publicly funded child welfare safety net was developed, sectarian and non-sectarian agencies created and funded various services analogous to today's child protection, congregate care, and foster care services. Since the emergence of publicly funded child welfare in the 1880s, state and local governments have paid private, voluntary agencies to provide services.[5] Historically, relationships between private and public agencies were non-competitive quasi-grant arrangements, but over the past decade, public-private agency relationships have taken very different forms.

In the current environment, contracting (also called "outsourcing") is the most common form of privatization in the areas of child welfare, behavior health and juvenile justice. Unlike the former informal, noncompetitive arrangements between public agencies and nonprofit providers, today's contracts are typically awarded after a competitive procurement process.

The manner in which payment is made also has changed. Until the past decade, public agencies typically retained management and policy control over the types, amount, and duration of services that were delivered by the private sector. Under this traditional child welfare per diem or fee-for-service contracting model, the private agency simply agreed to serve a certain number of children in return for payment based on a pre-determined daily or fee-for-service rate. The contractor was paid to deliver units of service and rarely was reimbursement linked to any measures of effectiveness of the services provided. Such a payment approach offered few incentives for service providers to control costs, to build a more suitable array of services as an alternative to placement, or to more quickly return children to their families. In fact, these contracts provided incentives to continue delivering more of the same service whether it was needed or not.

In recent years, over half of the state's public agencies have moved away from these traditional arrangements to a variety of risk or performance-based contracting options, often resulting in the contractor being given greater flexibility and autonomy in determining how funds will be used to meet the needs of individual children and families. The new privatization models are varied, but certain features have characterized most of these efforts:

- Public agencies have shifted case management responsibilities to private agencies;
- Public agencies are more likely to purchase results rather than services; and,

- Financing mechanisms increasingly link implicit or explicit fiscal incentives to performance.

Privatization in child welfare takes many forms, with the respective roles of the public and private sectors varying, depending on the financial arrangements and the nature of the service that is being privatized. In addition to the term *privatization,* these reforms have been called a variety of names: *public-private partnering, managed care in child welfare*, *community-based care*, and *results- or performance-based contracting*. Regardless of the term, most of these initiatives have placed an increased emphasis on outcomes, or value for money spent, with a goal of getting improved results for the same or less money.

By most accounts, the privatization of child welfare services appears to be on the increase. Some observers argue that the trend has brought higher quality and greater efficiency, but others have raised concerns about its appropriateness. Still others contend that the essential issue is not *whether* but *how* privatization should be accomplished. While the federal government does have a policy indicating that *inherently government functions* should not be contracted out,[6] federal law has not addressed the nature of state public agency/private agency child welfare contracts. Instead, child welfare public-private contracting has been governed by state law and regulation.[7] The ACF/Children's Bureau recently awarded funding to support a Quality Improvement Center on Child Welfare Privatization with the intent of building the knowledge base about effective privatization practices that may result in improved outcomes for children and families.

There are abundant sources of information about child welfare privatization. There have been *periodic national or targeted surveys* of public administrators conducted to collect both quantitative and qualitative information on the types and prevalence of changes; identify barriers and any perceived or actual successes; track trends over time and identify emerging issues; and report and disseminate findings, often including recommendations for improvement.

Other researchers have used *case studies* to look in-depth at one or more initiatives. Case studies have used combinations of document review and data analysis, phone interviews, and site visits. One of the most thorough and recent efforts to advance understanding of the current use of privatization, including the extent to which privatization achieved benefits or resulted in unintended consequences, was completed by Madelyn Freundlich of Children's Rights. Freundlich accomplished this in three ways: 1) by describing the concept and purported purposes of privatization; 2) using a case study approach to look at six different jurisdictions; and, 3) synthesizing the lessons learned and offering guidance to communities embarking on privatization.[8]

Some of the most detailed information on individual initiatives is found in *independent evaluations* (including evaluations of the two most comprehensive, statewide privatized systems, notably Kansas[9] and the University of South Florida's four-year evaluation of Community-Based Care in Florida).[10] According to the last CWLA management, finance, and contracting survey, over half of the 39 initiatives described in the report were planning, in the midst of, or had completed independent evaluations. Title IV-E waiver states that were implementing "managed care" type demonstrations are also required to conduct independent evaluations.

In the following section, principal findings are synthesized from the various sources, with updated information from a number of States that have changed course or enhanced privatization initiatives since the last published reports.

National Trends[11]

For nearly a decade, the Child Welfare League of America (CWLA) conducted periodic surveys of all 50 states and the District of Columbia (and a number of counties) and published findings related to the types of changes, if any, public agencies were making in how they managed, financed, or contracted for services. Survey responses were often supplemented by documents provided by the public agency respondents, including planning documents, RFPs, contracts, and evaluation studies. The last published report in 2003 was based on responses from 45 states and the District of Columbia obtained in 2000-2001. The reports provided detailed profiles and aggregate analysis of 39 initiatives from 25 states.[12]

Broad Goals & Impetus for Change

In all of the CWLA surveys, public agency respondents described overarching goals that related to legal mandates of safety, permanency, and well-being. Many also cited goals related to increasing accountability or purchasing results. Since the introduction of the Child and Family Service Reviews (CFSRs), it seems likely that as states weigh privatization options, they will introduce initiatives that respond to CFSR findings and link privatization efforts to the State's Program Improvement Plans.

A range of factors have motivated privatization initiatives. Some were made possible by the Title IV-E waiver program that allowed states more flexibility in how they spent federal funds. Others were a direct result of lawsuits, settlement agreements, or an overall negative public perception of how the public child welfare agency was performing. Increasingly, initiatives appear to be driven by legislative mandates (41% of the CWLA initiatives). No state has a broader legislative mandate than Florida.

Impetus for Change

Kansas's statewide initiative was implemented as a result of a lawsuit as well as pressure from the governor and legislature to privatize services.

The performance-based contract reform in the District of Columbia is part of the federal court settlement agreement that allowed the public agency to emerge from receivership.

Most recently, in 2005, the Texas legislature passed a bill requiring the public agency to develop and gradually implement a plan for privatizing foster care, adoption, and case management services for children requiring out-of-home care (SB6).

Legislative Mandates in Florida

In 1996, the Florida Legislature mandated four pilot programs that privatized child welfare services through contracts with community-based agencies.

In 1998, HB 3217 mandated statewide privatization of all foster care and related services. R*elated services* included family preservation, independent living, emergency shelter, residential group care, therapeutic foster care, intensive residential treatment, case management, post-placement supervision, adoption, and reunification. Child protective service intake and investigations remain in the public sector to be managed by DCF or by the sheriff's departments.

The Scope

Most privatization initiatives are limited to a particular region of the state. An initiative may be implemented in a small, defined area or the entire state. It may serve a subgroup of the child welfare population, such as children in residential or therapeutic levels of care only or it might serve a broad range of children in-home and out-of-home care settings. Some initiatives are small, contained pilots that stay small. Others eventually expand. A few projects from the onset were intended to cover most or all of the statewide child welfare caseload. Florida and Kansas are the two best-known examples of the latter. The last CWLA survey report estimated that approximately10-15 percent of the nation's children and families who are involved with the child welfare system are served by these new privatized models.

The Range of Privatized Services

Services included in the 39 initiatives described by CWLA varied depending on the target population.

The Hotline and the initial child protective services (CPS) investigation were retained by the public child welfare agency (or in some locales by law enforcement) in all of the 39 initiatives. Beyond those initial intake and investigation functions, however, the full range of child welfare services have been the focus of different privatization initiatives.

Arizona is not the only State interested in privatization of case management services. In the last CWLA survey, *the most likely service to be included in an initiative was case management (or care coordination), with over half of the initiatives including the privatization of case management*. Each initiative defined case management services in its RFP or contract with great variation among initiatives. In some initiatives, private agencies have assumed some or all of the core case management functions from the time of referral until the achievement of permanency. In these effort, private agencies are responsible for working with families to develop and implement the case plan, setting permanency goals, managing court related processes, making placement and discharge decisions, and recruiting, training and supporting foster and adoptive families. In Florida, for example, the private community-based lead agency receives the case during the investigation when it becomes clear that ongoing services (either in-home or placement) are needed during or post-investigation, and the lead agency retains the case until the case is closed. Case management is privatized for all children post-investigation regardless of whether the child is served in-home or out-of-home and whether services are provided under court supervision or under voluntary services.

In some states, case management is fully or partially privatized for a defined subset of the child welfare caseload, again with great variation. In some states, the focus of the privatized case management agency is on diverting low-risk children from the formal child welfare system during or following the investigation that is conducted by the public protective service worker (or, in some jurisdictions, by the sheriff's department). Arizona's Family Builders was an early example. More recently, in 2005, Iowa launched a similar community diversion initiative for children and families in need of services (but not an open CPS case) to be served by community-based providers. Under that model, the public agency retains case management for all other cases.

In other states, the emphasis has been on privatizing case management and services for children at the "deep-end" of the system, usually those who present with complex needs

and require group or residential levels of care. Many of the early models tracked by CWLA were focused on that small percent of cases that consumed a disproportionate share of resources. The rationale was that if children with complex needs could be better managed and stepped down or out of the system sooner, more children could be served for the same or fewer resources. Some efforts were more successful than others in achieving this goal. The *Commonworks* initiative in Massachusetts is an example of a successful effort. A portion of the State's children in need of residential care were referred to private agencies who coordinated care and provided or purchased services from other community providers. In this dual case management model, the public agency caseworkers retained final decision-making in terms of permanency goals and other key decisions, working in tandem with private case managers. (The Appendix contains more detail on *Commonworks* and an interview with a lead agency executive describing recent changes and lessons learned).

In some initiatives, children with complex service needs who are served by multiple public agencies are the focus. Cross-system funds are blended to support the coordinated case management and service system. The Missouri Interdepartmental Initiative is a good example of this approach. In that model, a private agency was given total case management responsibility for the children referred. (The Appendix contains a description of the initiative and an interview with a lead agency executive).

Some states have privatized case management for children in need of traditional foster care or home of relative care. The performance-based contracts in Illinois and Michigan provide examples of how States aligned payments with desired results in these program areas.

Many states have privatized case management for children with adoption as a permanency goal—with variation in the time the transfer of case management occurs (pre-or post termination of parental rights) and in the financing mechanism. Michigan was one of the earliest States to structure its payments to private agencies to reward timely achievement of adoptions with payments decreasing the longer the agency worked to find and place a child with an adoptive family. (See the Appendix for examples from Michigan, Massachusetts and Kansas).

With few exceptions, initiatives that privatized case management also have included the provision or management of many other services in addition to case management. For example, an agency responsible for case management might also be responsible for providing in-home and out-of-home care placement services, recruiting and licensing foster families, and providing pre-and post adoption services.

As noted in the examples, the degree of public agency involvement and ultimate authority in case management decisions has varied from one initiative to another. In some states, the public agency has delegated virtually all control to the private contractor (see Florida, for example). In other initiatives, the private agency has control over certain decisions but the public agency retains control and requires prior notification for significant milestones and has veto power over key decisions.

In most privatization models, the public agency relinquishes responsibility for some or all case management services and assumes the role of system monitor. The public agency sets the standards, defines the outcomes and performance expectations, and then monitors performance through contract monitoring and quality assurance and improvement activities.

Structural Designs

There is no one "business model" or structural design for privatization that has been proven to be superior to another. When public agencies contract for case management and other services, they typically rely upon private, nonprofit contractors. Fewer than 10% of the CWLA initiatives, for example, contracted with for-profit entities.

CWLA reported the majority of initiatives are using a *lead agency model* (51%) supported by a provider network or other collaborative service delivery arrangement. The lead agency model is what is being used under Florida's Community-Based Care plan and the Kansas privatization model. Under this type of arrangement, the public agency contracts with one or more agencies within a designated region to provide or purchase services for the target population from the time of referral under the obligation ends—often at case closure. Some lead agencies provide most, if not all, services with few or no subcontracts. Others may procure most services from other community-based agencies and directly provide case management and/or limited services. Some contracts impose a cap on the services that the lead agency can deliver if it assumes case management.

Finding

In all of its various forms, the lead agency model has been the most common arrangement in child welfare privatization.

Lead Agency Responsibilities in Florida

In the last five years Florida has transitioned to a community-based child welfare system. The Department has contracted with 22 regionally defined lead agencies and each must have the capacity to:

- Develop a comprehensive array of in-home, community-based, and out-of-home care options through a provider network;
- Manage the funds and address cost overruns;
- Provide or subcontract for the direct provision of all services needed by all children referred by the PI—in-home services, foster or kinship care, adoption, Independent Living.
- Approve, review, authorize, and pay provider's claims;
- Design and implement a comprehensive, individualized case management system
- Develop 24/7intake and referral capacity;
- Ensure child & family involvement and satisfaction at all levels of case management and service delivery
- Handle all court-related processes;
- Establish a quality assurance system to ensure continuous improvement;
- Meet all specified safety, permanency, and well-being outcomes and system performance indicators as required by the contracts; and,
- Gather and report all information required for quality and performance oversight.

Some lead agencies are single agencies that have long histories as child welfare service providers, while others are newly formed corporations that were created by several private agencies for the sole purpose of responding to the contract opportunity. A few lead agencies were created through collaboration between nonprofit agencies and one or more for-

profit organizations.

Performance-based contracts between the public agency and private providers are found in nearly a quarter of the CWLA initiatives. In this model, either payment amounts or schedules are linked in new ways to performance or achievement of certain case milestones, or the providers are given case rates for certain populations and expected to achieve specified results. Illinois was among the first states to implement performance contracts for kinship and foster care providers. In FY 2000, slightly more than 21,000 children were served statewide using performance contracts. This shift was accomplished by redesigning how new children are referred to foster care agencies for placement. When performance contracting was implemented (initially in Cook County), all agencies were required to accept an agreed upon number of new referrals each month with the expectation that a certain number would exit care to permanency. Falling short of the benchmark (24%) meant serving more children without additional funds. In Illinois, agencies must absorb the costs of any uncompensated care. If the number of children in excess of the payment level exceeded 20% of the number served, the agency risked the loss of the contract. By exceeding the 24% benchmark in permanency expectations, an agency could reduce the number of children served without a loss in revenue. Agencies received $2,000 for each child moved to a permanent placement beyond the contract requirement.

Performance-Based Contracting in Michigan

Michigan began the Foster Care Permanency Initiative as a pilot project in 1997 in Wayne County (Detroit). The goals were to reduce the length of stay in foster care and increase the numbers of children who achieved permanency within the specified timeframes.

The planners created the funding structure to provide foster care providers with flexibility. The principal design is a reduced per diem rate and a reallocation of the resulting savings into three lump sum incentive payments tied to performance goals.

There are few strings attached to the lump sum payments—allowing providers to purchase or provide whatever services or supports are needed to achieve the results.

Lump sums are paid at designated milestones of each case—an initial referral payment, a performance payment, and a sustainment payment. The daily rates and the incentive amounts have changed multiple times since the project was first launched.

Public agencies are increasingly using performance-based contracts with both lead agencies and with single providers. In some instances the performance-based trend is a direct result of legislative action or litigation. In Iowa, for example, the *Better Results for Kids Initiative* calls for the State to move towards performance-based contracts with all service providers. Similarly, for the past three years, the District of Columbia has been transitioning to performance-based contracts for the requisition of all services as a requirement of its settlement agreement approved by the federal court.

Quality, Accountability & Performance Expectations

Regardless of the structural model, public agencies are focused on improving quality—with all initiatives including some methods to collect and manage utilization, quality, outcomes, and fiscal data. Perhaps the most important change with privatization relates to what gets monitored. In many traditional child welfare programs, monitoring mechanisms, to the degree that they existed, focused almost exclusively on process issues, i.e., were certain tasks performed (evaluations, number of visits and therapy sessions, etc.). The new initiatives are part of a broader trend that seeks to follow client outcomes in addition to or instead of process indicators.

Most initiatives specify performance standards, improved functioning indicators, and client satisfaction requirements in their RFPs and/or contracts. Specific outcome measures vary according to the target population served by the initiative but initiatives are most likely to include indicators related to child safety, recidivism/reentry, and achievement of permanency within the timeframes required by the Adoption and Safe Families Act (ASFA).

States and counties use multiple methods to collect and manage data on their privatization initiatives. Many plans appear to rely heavily on reports generated by the contractor or from the State's automated MIS. However, both the findings of the independent evaluators and the responses to the 2001 CWLA survey indicate that data collection and management remain challenges for public and private agencies across the county.

Finding:

There is a premium placed on data collection to support QA/QI and contract monitoring but there is also evidence that current automated systems may not be up to the task.

The CWLA survey also asked whether the Statewide Automated Child Welfare Information systems (SACWISs) were used to collect and report cost, outcomes, and utilization data for the initiatives described. Twenty-eight initiatives (71.8%) answered this question, and of those, only five (17.9%) stated that they were using SACWIS for the initiative. Fourteen respondents indicated that they had plans to adapt their SACWIS to collect this type of information, representing 63.3% of the 22 states that answered this question.

Respondents also were asked whether their state or county had the ability to track the overall effect of the child welfare initiative on other child-serving systems. Only four of the initiatives reported this capability. The lack of ability to track utilization, costs, and outcomes for children and their families across child-serving systems is problematic. There is also a gap between information that is tracked and information that is actually used for system planning and improvement. Child welfare initiatives appear to have difficulty generating data in a form and in a time period that is relevant and helpful for planning and decision-making.

In addition to data obtained from the MIS and standardized assessments, states and counties reportedly use a variety of approaches to monitor performance. Frequently cited methods for collecting outcome and performance information include:

- Reviewing quarterly reports,
- Reviewing case records,
- Using quality assurance protocols,

- Using monthly problem-solving meetings,
- Making site visits,
- Reviewing disrupted placements and critical incidents, and
- Conducting independent evaluations.

Funding Sources

Finding

The core funding reported for the child welfare initiatives comes primarily from child welfare sources, but the vast majority of initiatives (72%) are increasingly supported by other funds, particularly Medicaid and mental health.

The bulk of federal child welfare funding is disproportionately directed toward out-of-home care—the very part of the system that public agencies are seeking to minimize. Given the complexity of child and family needs and the inadequacy of child welfare funds to support preventive, home-and community-based care, and therapeutic services, child welfare agencies have traditionally tapped other federal, state, or local funds that come from multiple agencies. Each funding source may come with different program eligibility and match requirements.

As child welfare agencies strive to rearrange fiscal relationships, payment mechanisms, and introduce risk based contracting, they have to also ensure that the proposed changes will not negatively affect their ability to access funds from sources outside child welfare or to maximize federal revenues. To accomplish these goals, some States (like Arizona) have operated under a Title IV-E waiver allowing the state to spend Title IV-E funds on a range of alternatives to foster care as long as the overall expenditures are cost-neutral to the federal government. Others have attempted to maximize federal revenue and gain greater flexibility over limited dollars by changing the funding mix—combining child welfare, TANF, Medicaid, and behavioral health block grant dollars in new ways to support children and families involved with the child welfare system. When multiple funding sources are used, the child welfare agency has had to reach agreement across child serving agencies on how funds will be included in the risk-based contract or made available to the child welfare contractor or public agency by some other means.

The 2001 CWLA survey explored the sources of funds used by child welfare agencies to support their child welfare initiatives. Most initiatives were supported by diverse funding sources. For example, of the 36 initiatives that identified funding sources, 26 of them (72%) reported using funding from outside the child welfare system. Consistent with findings in 1998, Medicaid and mental health funds were the most likely sources of funds to be used in combination with child welfare funds to support the initiatives. The use of TANF funds was on the increase. In 1998, less than 17% of the initiatives included TANF funds, compared to 30.6% in 2001.

There is, however, a continuing downward trend related to the use of substance abuse and education funds in these initiatives. In 2001, only 11.1% of the child welfare initiatives reported that they used substance abuse funds, despite the need for access to early intervention and treatment services, especially for the parents of children served by the child welfare system. This level is a slight decrease from the 1998 finding, in which 13% of the initiatives reported using substance abuse funds. Education funds were the least likely funds to be used in the initiatives.

There was a slight increase in 2001 in the number of initiatives that were described as Integrated Systems of Care. In many instances, projects were initiated with various federal and foundation planning funds with the explicit purpose of integrating services across public systems, maximizing federal revenue, and creating seamless and flexible systems for children served by public agencies. Many of these new models are publicly managed but with innovative privatized contract arrangements that also create incentives at the service level.

Wraparound Milwaukee: An Integrated System of Care

Wraparound Milwaukee has been in existence since 1995. Wraparound currently serves about 1000 children who have serious emotional disorders and who are identified by the child welfare or juvenile justice system as being at risk for residential placement; children with behavioral health problems who are referred by child protective services who have not yet been removed from home; and, a population of mothers (and their children) who are involved with the substance abuse, welfare-to-work and child welfare systems.

A combination of federal, state, and county funds is used to finance the system. A pooled fund is managed by Wraparound Milwaukee, housed within the Milwaukee County Mental Health Division, which acts as a public care management entity. Wraparound Milwaukee utilizes managed care technologies, including a management information system designed specifically for Wraparound Milwaukee, capitation and case rate financing, service authorization mechanisms, provider network development and utilization management, in addition to coordinated care management, provided by private agencies.

The overall reduction in expenditures from 1996 to 2000 has resulted in $8.3 million in savings for the County.

Risk-Based Financing Options

As in previous years, the CWLA 2001 survey revealed significant variations in financing arrangements among the child welfare initiatives. The arrangements may even vary within the same initiative over time or between different county initiatives within the same state. The level of risk ranges from *global budget transfers*, to capped allocations or capitation, to *case rates*, to discounted Fee-For-Service or per diem arrangements that include *bonuses and/or penalties* based upon performance or case milestones. Each of these options, as it is typically used in child welfare, is described below.

Finding

Over 90% of the child welfare initiatives include changes in financing or payment practices to create incentives for performance. Many initiatives include more than one mechanism to align payment with desired results.

Capitation, Capped Allocations, & Global Budgets

In the purest managed care financing model, a contractor is prepaid a fixed amount for all contracted services for a defined, enrolled population on a monthly basis. This per member, per month, population-based payment arrangement is referred to as *capitation*. In this type of arrangement, the contractor is at risk both for the number of children who use services and for the level or amount of services used. The contractor receives the predetermined amount based on the number of enrolled children regardless of the number of children who actually use services or the level of services that enrolled children require during the month. If the contractor enrolls children who subsequently underutilize services, the contractor will make a profit. Conversely, the contractor is exposed to significant financial risks if the plan is not adequately priced or if the eligible enrolled population uses more services or more costly services than projected.

Capped Allocations in Colorado

In creating the six child welfare managed care pilots, the state collapsed seven categorical funding streams into a single child welfare block grant. Only core services (including prevention, family support, etc.) remained as a separate primary funding stream with separate accountability and accounting. Funds from the block grant could be shifted into core services, but core services funds could not be spent on placement services.

The pilot counties have assumed full risk for child welfare costs in excess of the capped funds. Each of the counties has had the flexibility to also enter into various arrangements at the local level to share risks with the mental health and substance abuse agencies and with local providers or provider networks. Any spending above the cap is the responsibility of the county, with the exception of any risk-sharing agreements with other agencies or providers.

There are a number of reasons cited by child welfare administrators for not extensively using pure capitation models in child welfare. Part of the challenge has been the lack of accurate data that can be used in an actuarial model to project for the general population what percent will require services from the child welfare system, at what level, for what period of time, and at what cost. Another serious challenge is the relatively small number of children who will be enrolled as compared, for example, to covered lives under a public sector managed health care plan, making capitation for child welfare very risky.

Several public agency child welfare initiatives include reimbursement methods that resemble capitation. For example, in many of the county-administered initiatives, the state provides the county a *capped allocation*, and the county assumes responsibility for managing and delivering (or purchasing) child welfare services under this block grant. Under such arrangements, the county agency is often also given increased flexibility and control over resources and the ability to retain savings. The county agency may decide to share risks and case management responsibilities with individual service providers or lead agencies.

There are also several lead agency models that include financing arrangements that resemble capitation. In Florida, nonprofit lead agencies operate under a *global budget transfer*. They are given a predetermined percentage of the state's annual operating budget and asked to provide all services, in whatever amount needed, regardless of how many children and families in their geographic area may require services. The allocation is based in part on historic caseload size and previous spending for the geographic area covered and in part on assumptions of how the new privatized community-based care systems will affect future utilization patterns and outcomes.

Case Rates

Under this arrangement, a service provider, private lead agency, or other managed care entity (MCE) is paid a predetermined amount for each child referred. The contractor is not at risk for the number of children who will use services but is at risk for the amount or level of services used. For the contractor, if the case rate amount is adequate, it is a "less risky" financing arrangement than capitation.

In child welfare contracts, the case rate could be *episodic or annual*. An episodic rate means the contractor must provide all the services from initial entry into the plan until the episode ends. The point at which payments stop and risk ends varies from one initiative to another. However, it is common for the contractor to bear some risk until specified goals are achieved, whether it takes days, weeks, or years. For example, a typical case rate contract for foster care services might extend financial risks for up to 12 months after a child leaves the foster care system. If a

Florida's Global Budget Transfer

The Department contracts with twenty-two lead agencies for a fixed dollar amount that approximates the appropriation that district offices previously received to provide all child welfare services with the exception of investigations and the Hotline. Lead agencies are allowed and, in fact, are expected to access other funding sources, such as Medicaid for therapeutic services and local funding for prevention and early intervention.

In addition to the funds to support services, a formula had to be established under which DCF would transfer administrative and management resources (including capital equipment) to the lead agency based on a calculation of the pro-rata share of public agency positions eliminated as a result of privatization.

Prior to the introduction of lead agency contracts, DCF acknowledged that fiscal inequities and perverse disincentives existed in its methodology for allocating funds which resulted in greater allocations to districts that had higher placement rates and longer lengths of stay in foster care. Using risk-modeling technology, DCF attempted to more equitably distribute funds and reward districts that achieve better performance related to permanency, safety and well-being. Equitable funding may be achieved over time but is not yet fully evident, resulting in some lead agencies getting higher levels of funding than others. When fully implemented, there will be over $400 million in contracts with lead agencies.

Finding

The most common risk-based financing model in child welfare is a case rate.

child reenters care during that time, the contractor may be responsible for a portion (or all) of the cost of placement services.

Under an annual case rate, the provider receives the case rate amount each year the child is in the child welfare system and the contract is in effect. In both annual and episodic case rate arrangements, the payment schedule could be a monthly per child amount or it could be divided into lump sum payments that could be linked to attainment of various outcomes. An episode of care case rate is far riskier for the contractor than an annual case rate due to the many factors outside of the contractor's control that may extend the time it takes for the episode to end.

Bonuses and Penalties

As noted with the performance-based contract description, more public agencies appear to be aligning payment schedules and/or payment amounts to outcomes or results.

A number of states with fee-for-service arrangements, case rates, or other financing arrangements are also adding bonuses and penalties based on performance. Initiatives differ widely in the selection of performance measures and in the incentives that are provided. In some initiatives, only bonuses are included; in others, only penalties; and in yet others, both bonuses and penalties are included.

A number of other states and counties are experimenting with bonuses, penalties, or both that are added to case rate payments if the provider meets expectations.

Mechanisms Used to Limit Risks and Savings/Profits

Before examining the mechanisms used to limit risks, it is necessary to understand what the risks are. Every fiscal strategy, even a traditional fee for service arrangement, has risks—the potential for

Episode of Care Case Rates in Cuyahoga County, Ohio

The county child welfare agency uses an episode of care case rate in a pilot that targets a portion of the county's caseload of children, from birth to age 14, who are in specialized foster care or higher levels of care. Only children who have behavioral or health care needs and their siblings are in the pilot. The case rate amount ($50-53,000) was established through an RFP process.

The case rate is designed to cover the period of custody to permanency, plus 9 months (12 months for children who are adopted) and assumes that at least 50% of children achieve permanency within 12 months.

The payment schedule for contractors calls for 18 equal monthly payments for each child/family. The payments are made whether the child remains in care the entire 18 months or longer or achieves permanency sooner. If the child achieves permanency and remains stable for nine months, the financial obligation of the contractor ends. If the child reenters care within nine months of permanency, the contractor must take responsibility for the child's care and services within the original case rate.

Bonuses and Penalties

Cuyahoga County, OH includes penalties but not bonuses in its lead agency contracts. The lead agencies serving children ages 14 and younger must achieve permanency within 36 months for 80% of the children served.

The lead agency serving children 12 and younger must achieve permanency within 36 months for 87% of children served. For every child over the allowable standard who has not achieved permanency, the provider will be fined $3,600.

revenues and expenditures to vary. When revenues exceed expenditures, there is a surplus, which can be taken as profit or reinvested in the system. When expenditures exceed revenues, there is a loss. The risks can be found in the number of children who use services, the unit costs, the case mix, the volume, and the duration. Risk-sharing is a function of determining who is responsible for each type of risk. There are different inherent risks associated with each of the previously described risk-based financing options.

Finding

The vast majority of the privatized contracts that include financial risks for private agencies also have some mechanisms to limit risks.

Because of the newness of risk-based contracting, the uncertainty in calculating the rates, and the likelihood that the contractor will be a nonprofit agency with limited capital reserves, most child welfare risk-based contracts also include mechanisms to ensure that contractors remain solvent and stable. The most common mechanism in child welfare initiatives is a *risk-reward corridor*. In addition to protecting contractors from excessive loss, the purchaser may also limit the contractor's ability to retain profits or savings.

Ohio Risk and Reward Corridors

In the Cuyahoga County case rate pilot, one contractor has accepted full risk, and the other two have a 10% risk corridor. There are limits on how potential retained savings are used by all contractors. The contractors may request up to 30% of retained earnings be used for department-approved start-up costs.

In Franklin County, lead agencies are protected from excessive financial risk through the establishment of a stop loss that will pay 50% of direct service costs if total costs for an individual child exceed four times the case rate. The contract also includes risk-reward corridors that prevent lead agencies from gaining or losing more than a set percentage each year. In the first year, the risk corridor was 10% of the total budget, in the second year it was 15%, and in the third year it was 20%.

In the Hamilton County Creative Connections initiative, the arrangement in 2000 with the lead agency included both individual and aggregate stop-loss provisions.

Child welfare purchasers have found other methods of limiting a contractor's risk. For example, some child welfare case rates cover certain services typically reimbursed under Title IV-E funds, but the contractor is expected to bill Medicaid under fee-for-service arrangements to supplement the case rate. Or, in an attempt to better match level of risk to level of need, purchasers might propose *risk-adjusted* or stratified rates for children with different levels of service needs. Using a similar logic, in a few initiatives the purchaser allows the contractor to be reimbursed outside the risk arrangement on a fee-for-service basis for a certain number of children. In some instances, the contract includes *aggregate or individual stop-loss provisions* that limit the contractor's losses when expenditures exceed a certain amount for an individual child or for the entire covered population. Another method that is infrequently used in child welfare is a *risk pool* that can be accessed to cover unexpected costs under specified circumstances. The degree of exposure to risk and the potential for reward can also change over time within the same initiative.

Pricing the System and Assessing and Adjusting the Rates

> **Finding**
>
> In child welfare contracts, initial rates have often been developed with inadequate data or risk modeling tools. It appears when rates change based on actual costs the change is more likely to result in increased rates for providers.

Child welfare initiatives have varied in their approaches to pricing the overall system, establishing rates for contractors, timing the introduction of financial risk, and adjusting rates over time. Some child welfare initiatives introduced financial risk during the initial implementation; others phased-in risk after some period of time—often after the first year of cost and utilization data collection and analysis. In some initiatives, the public agency allowed the competitive bidding process to set the price and establish the rates. In other initiatives, the rate was specified in the RFP.

In most instances, the overall budget for the initiative is initially based upon estimates of what similar services cost under the traditional system. The risk-based rates are also calculated on the basis of rates paid under per diem and fee-for-service arrangements. Many respondents to the CWLA surveys reported difficulty in accessing accurate historic data to guide them in pricing the system or establishing the rates. For example, few child welfare agencies have had the ability to estimate with confidence the costs of serving a child from entry to exit from the system as a foundation for developing an episode of care case rate. As a result of the initial guesswork, it has not been uncommon for states to err in pricing the overall initiative or in setting rates, with, at times, mid-course corrections being made.

The last CWLA survey did not specifically ask whether or how child welfare initiatives periodically assess the adequacy of rates. Anecdotal evidence suggests that at times, rates are adjusted based on state or county fiscal or political factors that do not necessarily reflect evidence of the sufficiency of the rates. In other instances, the changes are made in response to fiscal audits or independent evaluations. For example, as a result of higher than expected expenditures after the privatization contracts were introduced, Kansas undertook an independent audit that revealed the following[13]:

- Start-up issues caused costs and lengths of services to be greater than anticipated. The auditors attributed many of the cost overruns to implementation problems, including difficulty attracting experienced social workers, larger numbers of referrals than expected, key infrastructure problems (including MIS development), and the individual learning curve of each provider.
- The largest variable in the overall cost of services was the type and amount of residential services used. The auditor noted that the renewed emphasis on family foster care appears to be reducing aggregate costs.
- The monthly cost was much greater than the bidders' projected estimates. The auditors estimated that cumulative costs were 65% higher than originally projected for foster care and 13.5% higher for adoption.

As a result of the under-estimation of costs and inadequate case rates, the Kansas foster care lead agencies experienced severe shortages in the first years of operation. By March 1999, one contractor (Kansas Children's Service League) had an operating deficit of $1 million; another (Kaw Valley Center) had a deficit of $6.5 million; and the third (United Methodist Youthville, which subsequently went into bankruptcy in June 2001 and since has reorganized) had a $7.5 million deficit. In an effort to address these issues, the Kansas legislature transferred approximately $50 million from the federal welfare-to-work program to foster care. [14]

Kansas Abandons Case Rates

In February 2000, Kansas abandoned its episode of care case rate approach altogether and instituted a per-child, per-month capitated rate payment system. The Kansas Department stated the following to a legislative oversight committee with regard to the agency's decision to dismantle the case rate system:

"The financial review process created concerns regarding the viability of the case rate as the payment system for foster care. The primary concern was that the contractors did not have adequate control over when children returned home or moved to another permanency [arrangement] to manage their finances in such a payment system. Specifically, courts, SRS and others played a significant role in how soon a child could achieve their case plan goal. This left the contractors in a situation where their financial risk could not be appropriately balanced with their case responsibility..."

Fiscal Assumptions and Actual Performance

While cost containment or the re-direction of resources may be among the goals of the child welfare initiatives, many of the respondents to CWLA surveys indicate that the risk-based features they have incorporated also mirror best practice in child welfare. In fact, fiscal and purchasing changes do not appear to reflect a shift in ideology but rather recognition of the power of financial incentives to change practice.

Although child welfare respondents have rarely indicated that containing or reducing overall child welfare costs is the principal goal of the initiative, most initiatives do, however, have expected *budget neutrality* and the redirection of resources to provide more appropriate services to more people with the same dollars. In most initiatives, there were built-in assumptions about what effect the proposed change would have on costs. CWLA survey respondents were asked to compare actual fiscal performance data (if available) to fiscal assumptions that were made when initiatives were designed. Based on child welfare respondents report, no one-to-one relationship was found between fiscal assumptions and performance.

Some initiatives were not designed explicitly or intended to save money, but they have (Illinois, for example), whereas others were intended to be cost neutral and have, in fact, cost more (Kansas, for example). Only three states expected the initiative to cost more than the previous system, but fiscal performance data indicate that 10 initiatives cost more than the previous system. In some instances, States reported they were pleased with results because funds had been re-directed, enabling more children and families to receive services at the same or slightly more costs.

There is little in the way of comparative analysis of risk-based initiatives with different structural designs to indicate that one structural or financing model is superior to another or, for that matter, superior to traditional contract arrangements.

It is important, however, that a publicagency fully understand the pros and cons of each type of risk-based option and the potential opportunities afforded by different structural designs before making decisions. Some of the issues that must be considered are fairly straightforward; others require a full appreciation of how all the design pieces need to fit together to achieve results. It is also important to recognize that the ultimate success of an initiative may relate to many factors separate from the structural model and the risk option chosen.

Summary & Commentary

What is clear across published reports is that there is broad interest in privatization; there is great variation in the scope of current initiatives (in terms of geographical reach, target population, the number of clients served, and structural design); there is variation in financing mechanisms but with a common thread that attempts to link improved performance to reimbursement amounts or payment schedules; there are different approaches to defining and monitoring results but most initiatives are focused on outcomes related to state and federal mandates; and, there are mixed findings as to actual success related to effectiveness and efficiency (costs).[15]

Overall, the child welfare privatization initiatives have been consistent in some aspects since they first emerged a decade ago. Public agencies are still partnering predominantly with nonprofit agencies. The driving forces have also been consistent but with a broader involvement of the legislature in more recent years. States appear to be focused on improving quality and are increasingly turning to independent evaluations to confirm results. Risk-sharing arrangements are commonplace, but with new twists that more directly link payment schedules or amounts to performance.

Every child welfare initiative has had to wrestle with basic design and procurement questions relating to the type of risk or results based financing arrangements that will be used and the types of organizations that will be allowed to participate in the bidding process. There appear to be many reasons why some initiatives succeeded and were later expanded and others failed to achieve fiscal and programmatic goals and were dismantled. At times, plans failed because they had design flaws from the outset or because there was not a balance between expectations, authority for decisions, and resources. It is encouraging that many initiatives appear to focus on increasing family involvement, cultural competency, and wrap-around approaches to service planning and delivery. Less promising is the fact that many states and private agencies still struggle to track basic utilization, cost, and outcome data within child welfare and across other child-serving systems to analyze the effect of various privatization initiatives.

In the past few years, more initiatives have undergone fully independent evaluations. However, the evidence is mixed. For example, the University of South Florida's evaluation of twenty-eight Florida counties in which community-based care (CBC) was operational found great variability in the performance of the CBC sites on different indicators related to safety, permanency, and well-being, in part due to the different stages of the implementation process and in part due to the significant variability in their designs and the level of funding.[16] The overall conclusion about expenditures per child contained good news but also pointed to the need for patience in finding improved

results. CBC and non-CBC counties experienced similar average expenditures per child for the first four years of CBC, but not for the last three years, where average expenditures per capita were lower for CBC counties than non-CBC counties. Additionally, CBC counties spent a lower proportion of their total budget on out-of-home care than non-CBC during FY02-03. The Florida cost findings are similar to those of other independent evaluations, including the Colorado and Kansas evaluations.[17]

In regards to achieving specified outcomes, evidence is promising but still inconclusive in many areas. Again, the Florida evaluation found that the privatized CBC sites performed, for the most part, as well or better than the non-privatized sites. However, there was variability among the CBC sites –with some performing far better than others on certain outcomes but poorly, in comparison, on others. The most difficult areas to improve were those areas that are most difficult for public agencies as well—moving children safely into timely permanency without having an increase in re-entry or other undesirable outcomes.

Privatization may offer real opportunities to improve results, but the development and implementation of these arrangements present a host of challenges.

Challenges

The interviews with case management agencies (described in the Appendix) noted a number of challenges that were similar across the different projects and consistent with national research including the following:

- *Inadequate data collection and analysis capability*. Data are needed to guide decisions about the structure, programmatic directions, and financing methods; to develop appropriate outcomes and benchmarks; to assess whether those outcomes/benchmarks are being met; and to make decisions regarding needed changes. Typically, neither the information systems nor the data they produce are adequate for the public purchaser or for the contract providers, especially those operating under risk-based contracts. Data collection and analysis was an area of concern for three of the five agencies interviewed (MS, FL, KS).
- *Lack of role clarity between private agency case managers and public agency staff.* Public agencies do not relinquish legal responsibilities when they enter into contracts. It has been difficult in many initiatives to find the right balance in public and private agency roles and responsibilities. Efficiency has been undermined because the public and private sector roles were not clear or were duplicative. Private agencies have been placed in untenable positions under risk-based contracts when they do not have control over key decisions that impact risk. This issue was raised by four of the five interviewees (MA, MO, OH, and KS).
- *Inadequate service capacity*. Without adequate and appropriate services, privatization is not likely to achieve, safety, permanency, or well-being goals regardless of the management, contracting, or financing model. Yet, in many cases, the contractor has not had the authority or resources to fill service gaps that pre-dated the initiative. Resources outside of traditional child welfare funding sources are often needed to build the capacity needed. Lack of service capacity was an issue for four of the five interviewees (MA, MO, OH, FL).
- *Poorly defined or the wrong outcomes*. The importance of outcomes in privatization efforts has been emphasized consistently. However, it is not always evident that

outcomes included in contracts are the "right" ones or that they are defined in ways that are meaningful or measurable. Challenges related to outcomes were raised by three of the five states (MA, MO, Fl).

- *Resources that are not aligned with expectations*. When public agencies develop their privatization plans, the performance expectations are often higher than performance in the current system, while the resources are the same or less, making it difficult to achieve either programmatic or fiscal goals. This struggle was of concern to two of the five interviewees (MO, KS).
- *Problems with financing.* Significant variation exists in financing arrangements, with various approaches to pricing the initiative, establishing rates, timing the introduction of financial risk, and adjusting rates over time. Issues arise in relation to the underlying sources of funding, the fiscal methodology, and the mechanisms to address the potential impact of risk-sharing. After a decade of experimentation, there is still no compelling evidence of the efficacy of one financing approach over another. Recent evidence might indicate that the dominance of the case rate may be giving way to other performance-based contracting options. Challenges related to financing were raised all interviewees.
- *Lack of private agency expertise in family-centered practices, evidence-based innovations, or new business processes.* A downfall of many initiatives is the lack of knowledge or experience of the private agencies in managing risk, creating provider networks, introducing appropriate utilization management, adapting and using protocols and decision support tools to better match services to needs and improve services, and meeting the requirements of legal mandates that are at the heart of child welfare case management. Program and business expertise was an issue for all of the executives interviewed.
- *No magic bullet for staffing.* Private contractors have had to come to terms with the same challenges the public agency faces—namely the difficulty recruiting, supporting, and retaining workers and caregivers. Three of the five executives raised this as a primary concern.
- *Lack of understanding of legal issues and experience engaging the courts.* Significant difficulties have arisen when privatization plans failed to recognize the need for judicial buy-in. Court-related issues are especially important for public agencies to consider when balancing the level of risk with the degree of autonomy contractors have in decisions that affect risk. The Kansas experience with the initial launch of privatization should have been a clear warning for other States. Unfortunately, this issue continues to be a challenge in many initiatives. In other initiatives, as noted in the case studies, even though the case management is privatized, many states have ensured that the public agency's legal staff remain in place and in some instances, the public agency staff attend hearings with the private agency case managers.

Various researchers using different methodologies have identified additional challenges, including the following:[18]

- *Limited funding sources fail to meet complex needs*. Despite the higher prevalence of poor physical health and mental health and substance abuse issues among children and families, many privatization contracts are funded primarily with child welfare funds and have failed to include arrangements for accessing health, dental,

and behavioral health services that fall outside the contract. This funding issue has been a challenge for many of the Florida CBC agencies and the solutions have varied with different community responses.

- *Adherence to rigid procedures.* By accident or design, some projects have struggled because there were inherent barriers to innovation. Contracts often require adherence to day-to-day operating procedures required of public agency staff that were not flexible enough to allow contractors to succeed. Simply changing from a public agency to a private agency will not result in improved outcomes or efficiencies.
- *Flawed contracts.* In many initiatives, the RFPs and contracts are fraught with problems. In some cases, expectations are framed in ambiguous terms, making it impossible to determine what the private agencies were expected to do, what clients were expected to receive, and what results were to be produced. According to Madelyn Freundlich, "In sum, in many privatization initiatives, the dynamic was one of an inexperienced purchasing agent attempting to develop at-risk contracts with inexperienced sellers."[19]
- *Overdone or underdone monitoring*. Most public agencies have struggled to find the appropriate level of monitoring and oversight. Researchers have noted a tendency for micro-management in some initiatives, while in other initiatives, the level of monitoring seems woefully inadequate. Over time, the public and private agencies in many Florida CBC sites have struck an appropriate balance and have created some promising practices that merit further study. The HFC case example in the Appendix describes the model used.
- *Limited consumer involvement.* Organizations that have studied the essential features of privatization consistently have highlighted the importance of consumer involvement. Though it is a value articulated in most RFPs and contracts, it is unclear whether (and how) consumer involvement is actually occurring in the planning, implementation, monitoring, or evaluation of child welfare privatization.
- *Lack of attention to cultural & linguistic competence.* Nationally, systems of care for children are attempting to respond effectively to the needs of children and families from culturally and linguistically diverse groups. Again, though a principle in all child welfare policies, it is unclear whether cultural and linguistic competence is being considered or is improving under child welfare privatization.[20] Privatization efforts have also not fully engaged tribal governments or recognized the unique legal and practice requirements of providing services to Indian children and families.[21]

Key Success Elements

Key factors for success, across different designs, appear to relate to the sophistication of the purchaser in planning, procurement, and contract oversight; the alignment of resources with expectations; the adequacy of funding and contractor rates; the buy-in from stakeholders; the care with which system designs were developed; the clarity and appropriateness of the expected outcomes; and the infrastructure, leadership, and innovation of the contractor and the public purchaser. Successful privatization initiatives share a few essential characteristics in common with effective public agency programs:

- Strong and steady leadership

- Clear vision, goals, objectives, and performance criteria.
- Sufficient staffing and other resources to implement the vision
- Continuous and meaningful performance monitoring
- Specific, measurable outcomes
- State-of-the-art information systems that allow private and public service providers to track progress and outcomes
- Strong and committed leadership
- Defined roles and responsibilities
- Resilient interpersonal working relationships between public and private agencies
- Strong ties to the communities they serve
- New business tools and innovative practices.

It seems clear that privatization is best implemented through a broad-based planning process that engages stakeholders in a sustained dialogue for the purpose of reaching consensus on the goals of the privatization initiative. Reaching agreement on difficult decisions later in the planning process will be far easier if all parities are united in a shared vision.

At the outset of planning for privatization, it is also important for policymakers and decision makers to recognize that positive results will not be immediately evident. States should not expect to save money through privatization—at least not in the short-term. Greater efficiency and improved outcomes for children and families will not be achieved simply because private agencies assume primary responsibility for case management but rather because all of the agencies involved are committed to working together over the long haul to identify and remove barriers that stand in the way of achieving their shared vision.

Best Practices in Privatized Case Management Systems

Research studies have identified a number of promising approaches found in various types of privatization initiatives including the following:

- *Wraparound values/principles.* Many initiatives appear to be grounded in system of care principles. For example, the majority of the Florida Community-based Care plans described an approach to case planning and services delivery that reflects core values of cultural competence, family involvement, and individualized plans that addressed identified needs.
- *Family team conferencing*. The majority of initiatives that have included privatized case management require the contractor to use a shared family decision making model to develop and revise case plans. Many initiatives include standards and timeframes for convening teams and completing and revising plans. Providers are monitored to ensure that providers are meeting standards.
- *Evidence-based practices & decision support tools.* A few initiatives have specified a particular practice that the contractor is required to use (MST, for example). More often, the contractor has had to describe the clinical protocols or decision support tools that would be used to ensure quality and appropriate, individualized services. The public agency typically signs off on protocols before implementation.

- *Continuity in case managers.* Under traditional child welfare systems, it is not uncommon for a child and family to have different caseworkers depending on the services and case plan goals. For example, a child might have one caseworker if services are provided in-home and then be assigned a different caseworker if placement is required. If the goal becomes adoption, a different caseworker might take over the case. Under many of the new initiatives, a single case manager (or a case management team) is assigned to the case and the same caseworker retains responsibility from the time of assignment until achievement of permanency and case closure. Specialists might be assigned to assist the worker (adoption or independent living specialists, for example), but the child and family experience continuity in case management from entry to exit. This model is the dominant model in Florida.
- *National accreditation standards*. A number of states require contractors to be accredited by a national accrediting body (COA, CARF, JACHO) and they mandate that nationally recognized caseload standards be met. (It is not clear in some cases that the funding is sufficient to support the required caseload standards.) Florida, Kansas, Missouri, and Illinois, for example, require accreditation.
- *Expanded services through community service networks*. An explicit goal in nearly half of the initiatives described by CWLA was to expand the current array of services available to children and their families through the creation of a provider network. Often, the public agency specified the services and supports that had to be included in the network but allowed the contractor flexibility in developing network standards and contracts with service providers. In some instances, the private agency that is responsible for case management is also responsible for network development. In other instances, the case management agencies and agencies responsible for network development are different and are linked by contracts or interagency agreements.
- *Improved use of technology.* As noted previously, while many initiatives still struggle to build and maintain adequate IT, many have built capacity that has resulted in improved data collection and use of data at the case level and as a guide for future system improvements. With better data on outcomes and costs, many initiatives have succeeded in getting additional support from legislators.
- *Added training and supports for caregivers.* Many initiatives have given extra attention to recruiting and supporting caregivers (foster, adoptive, and kinship families). Many have added formal and informal supports, including additional respite, bonuses for recruiting other families, mentors or resource families for new families, and networking/communications mechanisms.
- *Promising contract monitoring practices.* While still problematic in many initiatives, promising approaches are emerging to monitor provider performance relative to compliance with contract terms and the achievement of specified outcomes. In several Florida sites, for example, quality service reviews are conducted on a regular basis by public and private agency staff. The Florida initiative has also developed an integrated management information system that allows the provider and the public agency to share access to real-time data and permits public and private agency staff to jointly track performance and problem-solve performance problems as they are identified.

- *Utilization Review.* In addition to case management, the last CWLA survey noted that many initiatives are taking a fresh approach to *utilization review* (UR). Although the approaches vary, as does the entity responsible for this function, the goal is to regularly assess cases and match services to identified needs using standard protocols, and to continuously monitor and adjust plans and services throughout an episode of care to ensure safety, permanency, and well-being. This approach has been a new concept for many public and private child welfare agencies. Over time, many initiatives have reportedly developed sophisticated UR capacity. Many of Colorado's pilot initiatives, for example, have placed a premium on strengthening their UR capacity.

Recent Developments

Changes may be made in financing arrangements or in the overall design of an initiative when it becomes clear that the contractor does not have control over the factors that result in unacceptable risks. As states and contract agencies fully assess the costs and benefits of their financing and contracting arrangements, it appears that many State and local initiatives have evolved from their initial plans. Some initiatives that were included in the CWLA 2000-2001 survey report, for example, have made significant changes in various aspects of the model subsequent to the report. Several of the initiatives, selected from the 39 described in the CWLA report, are highlighted to illustrate the types of shifts that have occurred:

- In Missouri, child welfare functions are the responsibility of the Division of Family Services (DFS) of the state Department of Social Services (DSS). DSS also includes the Division of Medical Services (Medicaid) and the Division of Youth Services (DYS) for juvenile corrections. There is a separate Department of Mental Health (DMH). In 1997, the then-Directors of DSS and DMH formed the Interdepartmental Initiative for Children with Severe Needs with funding from The Robert Wood Johnson Foundation, the Center for Health Care Strategies, and pooled funding from dollars provided by DSS and DMH. [22] At the end of the original contract period (February 2002), two of the original Initiative agency partners elected not to participate in the contract extensions. DMH, citing budget difficulties, withdrew, as did DYS, which believed that it already provided the services provided by the lead agency. These developments occurred shortly after the departure of the DSS and DMH Directors who were responsible for the creation of the Initiative.[23]

  While the initiative continues with the original contractor (through six contract extensions), the blended funding is now reduced to Medicaid and child welfare funds. The contract is due to expire at the end of 2005 and with a new performance-based contract reform underway, the future of the Interdepartmental Initiative is unclear. It appears that in the latest privatization effort in Missouri, the State has taken core elements from the previously described Illinois model which is not without critics who assert that the approach has driven numerous private Illinois agencies out of business, resulting in fewer and larger agencies providing care.

- In Hamilton County, Ohio, an inadequate case rate caused the contractor (Beech Acres) to use its own endowment to subsidize the Creative Connections program, an interdepartmental system of care initiative that targeted cross-system children with complex needs. At the time of renewal, Beech Acres' refusal to accept a

continuation of what it believed was an inadequate case rate ultimately led to termination of contract re-negotiations.[24] The county agency re-bid the initiative and a new provider (from out-of-state) took over the contract.

- The Franklin County, Ohio Children Services Managed Care Project was based on the Franklin County Children Services (FCCS) agency agreement with the county Alcohol, Drug Abuse, and Mental Health (ADAMH) Board and was intended to facilitate better access to behavioral health services by children and families in the child welfare system. The agreement fell apart in 2002. Several reasons were given for the termination of the ADAMH agreement. Among other issues, a recent case study, cited ongoing underfunding of the ADAMH Board and the arrival of a new ADAMH director who did not support the agreement.[25]
- The Permanency Achieved Through Coordinated Efforts (Project PACE) initiative in Texas targeted children with therapeutic needs and their siblings who entered the foster care system from counties that surround Fort Worth. At the time of the CWLA survey, the contractor was expecting to serve approximately 500 children with a budget of approximately $14M under a fixed rate contract of $77/day per child, regardless of the level of out-of-home care. The project was dismantled shortly after the CWLA survey report was published.

  More recently, in 2004, Governor Rick Perry issued an executive order directing the reform of the state's CPS system. The Governor declared the condition of the system an emergency issue and called upon the 79th Legislature to act decisively to provide the resources and reforms necessary to ensure the safety and well-being of Texas children. Senate Bill 6 established a framework for reform by requiring the Department to privatize substitute care and case management services. The legislation also requires the Department to create a multi-disciplinary quality assurance team to ensure that contract, program and licensing requirements are met. Both the independent evaluator and the multi-disciplinary team will submit regular reports to the Legislature on the progress and performance of substitute care and case management service providers.
- The *Commonworks* initiative in Massachusetts was one of the earliest case rate lead agency models that served children with intensive needs. The original financing was no-risk for 18 months to allow the agencies and the State to track actual costs and outcomes. The case rate that was introduced was based upon that assessment. In recent months, *Commonwork*s has been dissolved and absorbed by a new initiative. The previous case rate (that also included bonuses and penalties) has been abandoned for a non-risk cost-reimbursement model solely for case management services, with direct services being reimbursed by the State agency. (The new model is described in the Appendix)
- The latest Kansas privatization contracts were awarded in 2005. As in previous re-bids, changes were made in how case management services are provided and reimbursed and the contract agencies have changed. (See Kansas Case Study in the Attachment).

It is unknown how many other initiatives reported by CWLA or other research projects have changed their original privatization project. The fact that some of the early initiatives have changed course appears to be due in part to changes in the State's

overall priorities, changes in leadership, or a natural evolution brought about by increased knowledge about what worked and what did not.

Many initiatives are introducing a variety of strategies to ensure sustainability in the face of leadership changes or economic downturns. Regardless of the mechanism used, the goal is to build a broader base of community involvement and ownership of the project. Some states have legislatively mandated bodies to oversee the initiatives, serve as a voice for the community, and identify and access the resources needed to support the initiative. Florida is a good example. Community Alliances are charged by statute with a range of responsibilities: "joint planning for resource utilization in the community; needs assessment and establishment of community priorities for service delivery; determining community outcome goals to supplement state-required outcomes; serving as a catalyst for community resource development (local community dollars are used as match for various federal funds); providing for community education and advocacy on issues related to delivery of services; and promoting prevention and early intervention services" (Florida Statute §20.196[b]).

In general, it is felt that the last published national CWLA study in 2001 underreports the scope of privatization efforts that are currently underway. Several states that did not respond to the survey are known to have statewide initiatives (Tennessee's Continuum of Care contracts, for example). Additionally, since the report was published, new initiatives have been launched in several States and the District of Columbia.

Endnotes

[1] The Health Care Reform Tracking Project (HCRTP) is co-funded by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. Supplemental funding has been provided by the Administration for Children and Families of the U.S. Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies, Inc. to incorporate a special analysis related to children and families involved in the child welfare system. All reports of the Tracking Project are available from the Research and Training Center for Children's Mental Health, University of South Florida (813) 974-6271. Special analyses related to the child welfare population are available from the National Technical Assistance Center for Children's Mental Health at Georgetown University (202) 687-5000, deaconm@georgetown.edu.

[2] Freundlich, M. and Gerstenzang, S. (2003). An Assessment of the privatization of Child Welfare Services. Washington DC: CWLA Press can be ordered by email at books@cwla.org.

[3] This document is adapted from McCullough, C. (2003). Financing & Contracting Practices in Child Welfare Initiatives & Medicaid Managed Care: Similarities and Differences. CWLA: Washington, DC. Funded by the Center for Health Care Strategies. The other CWLA Issue Paper, *Highlights form the 2000-2001 Survey: Implications for Policy and Practice*, may be ordered through CWLA publications at http://www.cwla.org/pubs.

[4] Nightingale, D.S, & Pindus, N. (1997). Privatization of public social services: A background paper. Washington, DC: Urban Institute.

[5] Rosenthal, M. G. (2000). Public or private children's services? Privatization in retrospect. *Social Service Review*, 74(2), 281-305.

[6] Burman, A. (1992). OFPP Policy Letter 92-1. Retrieved August 2, 2005 from http://www.acqnet.gov/Library/OFPP/PolicyLetters/Letters/PL92-1.html

[7] Freundlich, M. (personal communication, September11, 2005)

[8] Freundlich and Gerstenzang, 2003. See also: M. Freundlich in Wulczyn, F. & Orlebeke, B. (1998). Four case studies of fiscal reform and managed care in child welfare. Chicago, IL: University of Chicago Chapin Hall Center for Children.

[9] James Bell Associates. (2001, March). *External evaluation of the Kansas child welfare system, July 2000-March 2001,* (FY2001 Third Quarterly Report). Arlington, VA

[10] Armstrong, M., Jordan, N., Kershaw, M.A., Pedraza, J., Vargo, A., & Yampolskaya, S. (2005). *Statewide Evaluation of Florida's Community-Based Care: 2005 Final Report*. Tampa, FL: University of South Florida, Dept. of Children & Families.

[11] McCullough, C. & Schmitt, B. (2003). Management, finance, and contracting survey final report. Washington, DC: CWLA Press.

[12] McCullough, C. & Schmitt, B. 2003.

[13] SRS "Foster care and Adoption Cost Analysis for Children and Family Services—Final report" (April 1999). Note: The independent audit was conducted by Deloitte and Touche.

[14] McLean, J. (March 12, 1999). Foster care, adoption need funding infusion. Capital Journal, p.2. See also, Ranney, D. (August 9, 2001). Graves weighs in on foster care crisis. Lawrence Journal World, p.2. (As cited in Freundlich, p. 46-47).

[15] McCullough, (2003), p 22.

[16] Armstrong, M., Jordan, N., Kershaw, M. A., Vargo, A., Wallace, F., & Yampolskaya, S. (2004).

[17] McCullough, C. & Schmitt, B. (2003).

[18] The challenges described were synthesized from the following sources: McCullough, C. & Schmitt, B. (2003); Freundlich, M. & Gerstenzang, S. (2003); GAO, Child Welfare (1998); GAO, Privatization (1998); McCarthy, J. & McCullough, C. (2003); Mauery, R., Collins, J., McCarthy, J., McCullough, C., & Pires, S.

(2003). Contracting for coordination of behavioral health services in privatized child welfare and Medicaid managed care. Center for Health Care Strategies, Inc.; Wehr, E., Rosenbaum, S., Shaw, K., & Valencia, R. (1999). Managing Child Welfare: An Analysis of Contracts for Child Welfare Service Systems. The Center for Health Care Strategies, Inc.; Austin, M. & Ezell, M. (2004). Educating future social work administrators. NY: Haworth Press. (Special Issue of *Administration in Social Work*, Vol. 28, No. 1).

[19] Freundlich, M. & Gerstenzang, S. (2003)

[20]Goode, T. D., & Jackson, V. H. (2003). Planning, implementing and evaluating cultural and linguistic competency for comprehensive community mental health services for children and families. Washington, DC: National Center for Cultural Competence, Georgetown University.

[21] Conversation with Terry Cross.

[22] Mauery, page 20.

[23] Mauery, page 21

[24] Freundlich, p. 208-211.

[25] Mauery, page 25-26.